Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PATIENTS CHOICE FAMILY MEDICINE AND REHAB
4801 S BUCKNER BLVD SUITE 200
DALLAS TX 75227

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

AMERISURE INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-10-4581-01

MFDR Received Date

June 21, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is to inform you of our submittal to MDR. For DOS 12/16/2010 our office received a denial stating 'Denied per Peer Review, This procedure is outside ODG guidelines which requires preauthorization.' I sent a request for reconsideration with an explanation letter stating this code does not require preauthorization. I then received second denial on 03/11/2010 stating 'Original payment decision is being maintained. This claim was processed properly the first time.' Same applies for DOS 01/28/2010 I received denial stating 'Denied per Peer Review, This procedure is outside ODG guidelines which requires preauthorization.' I sent a request for reconsideration with an explanation letter stating these procedures do not need preauthorization. ODG states not to automatically deny payment for no authorization. Patient was still under our care and was in the process to be seen for a DD appointment and specialist appointments. On 03/15/2010 I received a second denial stating 'Original payment decision is being maintained. This claim was process properly the first time.' I have made several attempts to get claims paid with no success."

Amount in Dispute: $249.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Patients Choice Family Medicine and Rehab has requested medical fee dispute regarding the dates of service of 12/16/2009 (CPT Code 97004), 1/28/20010 (CPT Code 99213), and 1/28/2010 (CPT Code 88080). It is this Carrier's position that the correct decision was made when the requestor's bills were denied for no preauthorization based upon the Peer Review by Dr. David McKenas dated 12/3/2009. This Peer Review was obtained to review the appropriateness of this claimant's treatment per the Official Disability Guidelines (ODG) as it relates to his accepted compensable injury of a facture to his left finger. Dr. McKenas opined that no further treatment would be consistent with the ODG for his pinky finger injury; therefore, all further treatment would require pre-authorization which was not obtained by the medical provider. Based upon the report by Dr. McKenas, it is the Carrier's position that the denial of the bills was appropriate as the treatment provided on 12/16/2009 and 1/28/2010 was not consistent with the ODG and the provider failed to obtain pre-authorization for the medical care."

Response Submitted by: Flahive, Ogden & Latson, PO 201329, Austin, TX 78730

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2009	CPT Code 97004	$249.00	$0.00
January 28, 2010	CPT Code 99213		
January 28, 2010	CPT Code 99080		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 15, 2010, February 23, 2010, March 8, 2010 and March 11, 2010:
   - 216 – Based on the findings of a review organization. Denial per adjuster – per peer review/peer review attached outside the ODG, preauthorization required.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time. Denial per adjuster – per peer review/peer review attached outside the ODG, preauthorization required.

Issues

1. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity. Documentation was not submitted to support that the issue(s) of medical necessity for dates of service December 16, 2009 and January 28, 2010 have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 15, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.